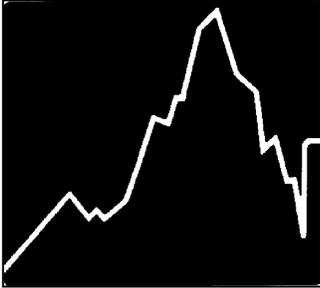


Print Name: _____



**Department of Health Professions
Commonwealth of Virginia**

**Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463**

**Telephone: (804) 367-4600
Facsimile: (804) 527-4426**

CERTIFICATE OF PROFESSIONAL EDUCATION (FORM B)
(For graduates of approved programs only)

It is hereby certified that _____
(Name of Applicant)

enrolled in _____ on _____
(Course of Study) (Date)

and received a diploma from _____
(Name of Institution)

conferring the degree of _____ on _____
(Degree) (Date)

(President, Secretary or Dean)

SCHOOL SEAL

Completed form must be sent to:

**Attention – Intern/Resident Applications
Virginia Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463**

This form will not be considered valid if submitted prior to actual date of graduation.